UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ENBREL (enteracept) for PLAQUE PSORIASIS

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- Diagnosis of Plaque Psoriasis
- History of incomplete response or intolerance to Methotrexate, Cyclosporin, and Acitrentin (soriatane)
- At least 10% of body surface area and/or palms, soles, head, neck or genitalia are affected based on: erythema, induration, scaling, patient global assessment of disease activity
- Dermatology consultation within the last 60 days.

INFORMATION:

- Enbrel may not be given with other biologic agents such as Interferon, experimental medications or combinations. Raptiva, Amevive and Enbrel are mutually exclusive. Patients may only be on one of these agents at a time.

AUTHORIZATION:

Initial is a trial of 12 weeks up to 50mg bi- weekly for 3 months, 48 kits maximum.

RE-AUTHORIZATION:

Maintenance dose for 12 months if patient has at least a 50% improvement from baseline. Area and severity based on erythema, induration, scaling and patient global assessment of disease activity.

One dose up to 50mg weekly, 52 kits maximum.

Yearly letter updating current response to Enbrel